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7802-A07-003

IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

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Applicants	:	Ryan Lance Levin et al.	
TC/A.U.	:	3626	
Examiner	:	Dilek B. Cobanoglu	
Docket No.	:	7802-A07-003	
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APPELLANTS' REPLY BRIEF

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Sir:

In response to the Examiner's Answer dated February 2, 2010, the due date for response to which is April 2, 2010, the Appellants hereby respectfully submit this reply brief in support of the their appeal to the Board of Patent Appeals and Interferences of the Examiner's final rejection of claims 1-10, 12, and 14-19 of the above-referenced application.

RESPONSE TO EXAMINER'S ARGUMENTS

Rebuttal to Examiner's Answer Directed to the Objection to the Specification Under 35 U.S.C. §132(a)

The Examiner has taken the position that Response With Amendment filed on February 17, 2009 introduced material into the disclosure and, therefore, objected to the Specification under 35 U.S.C. §132(a). Appellants respectfully traverse this objection. As will be shown below, the Specification as originally filed provides for the support subject matter of "wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values".

In the Examiner's Answer dated February 2, 2010 the Examiner states on pages 13-14:

> The added material: "a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values",
>
> Appellant points out figure 1 (column MH/U/W Ops.) and figures 3, 7 and 10, however the Appellant describes the information under "employer" column in page 7 of the arguments. The only description under "employer" in figure 1 is "((Employer) complete employer application form including employer level decision -compulsory, voluntary, or disallow Vitality membership for employees"). And specification recites: "FIG. 1 shows the procedure followed by a new employer joining a medical scheme (i.e. traditional indemnity health insurance plan) that utilizes the present invention. (In the specification, reference is made to the "Vitality" program of the applicant. It should be appreciated that the described scheme may not correspond exactly to medical schemes operated by the applicant from time to time)" in page 4, first paragraph. Even if we assume that "a default setting" is filling out a form, and checking a box for accepting membership of Vitality; then figures 1, 3, 7, 10 all describe different situations, such as figure 1: "New employer joins vitality", figure 3: "Claim vitality points for existing HRC/RWFL membership", figure 7: "Member/dependant visits run/walk for life", and figure 10: "Score various vitality points" and not all of the figures recite a form that the employer completes.

> It is already very confusing that the terms of "insurance provider", "Momentum Health" or "MH", "MH U/W Ops" where "U/W' is an abbreviation for "underwrite", "Discovery", and Scheme" have been used interchangeably in the Specification as originally filed to mean "insurance provider" (as explained by the Appellant in Remarks of 2/17/2009 communication); Appellant now points out all these figures of different situations as "a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values".

With respect to the Examiner's statement of:

> The only description under "employer" in figure 1 is "((Employer) complete employer application form including employer level decision -compulsory, voluntary, or disallow Vitality membership for employees"). And specification recites: "FIG. 1 shows the procedure followed by a new employer joining a medical scheme (i.e. traditional indemnity health insurance plan) that utilizes the present invention. (In the specification, reference is made to the "Vitality" program of the applicant. It should be appreciated that the described scheme may not correspond exactly to medical schemes operated by the applicant from time to time)" in page 4, first paragraph. Even if we assume that "a default setting" is filling out a form, and checking a box for accepting membership of Vitality; then figures 1, 3, 7, 10 all describe different situations, such as figure 1: "New employer joins vitality", figure 3: "Claim vitality points for existing HRC/RWFL membership", figure 7: "Member/dependant visits run/walk for life", and figure 10: "Score various vitality points" and not all of the figures recite a form that the employer completes.

Appellants respectfully point of that in FIG. 1 under the "Employer" column, the first box explicitly states (**emphasis added**) "Complete employer application form including employer level decision-**compulsory**, voluntary* or disallow Vitality membership for employees". As can be seen, FIG. 1 explicitly states that an employer can make participation in the Vitality program compulsory. The Examiner seems to have ignored the fact that FIG. 1 clearly shows that the employer can select employee participation in the Vitality program to be compulsory. FIG. 1 also distinguishes between compulsory or voluntary participation by stating "Where employer decision is 'Voluntary' either the employer specifies which employees are opted in or the employer allows employees to specify via the member application forms". Therefore, FIG. 1 clearly shows that a default setting for

participating in the Vitality membership can be compulsory, i.e. "wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values".

Furthermore, FIG. 1, under the "MH U/W Ops." column, shows that the system automatically checks if the employee out in/out decision is in line with the employer decision. In other words, the employer is first able to select a compulsory or voluntary participation for the employee. Then, under the "Employee" column of FIG. 1, the employee is able to select a participation level. Therefore, because the employer can apply a setting of compulsory prior to the employee's participation selection, the employer's selection of compulsory participation is a default setting. Under the "MH U/W Ops." column the system then ensures that the employee's selection matches the employer's selection and underwrites/activates the employer/employees accordingly.

Appellants, the Appeal Brief, referred to FIG. 3, FIG. 7, and FIG. 10 of the Specification as originally filed to show support for subject matter of "receive rewards based on accumulated credit values exceeding predetermined values". For example, FIG. 3 shows that a member (e.g., an employee) of the Vitality program can claim points and score points. FIG. 7 further shows that a member of the Vitality program can be awarded points for participating in a run/walk for life event. FIG. 10 also shows examples of accumulating points. Therefore, Appellants cited FIGs. 1, 3, 7, and 10 to show support for the entire claim element of "wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values". In other words, FIGs. 1 shows support for "wherein a default setting associated with the medical insurance plan is for all members to be opted-in" in the Vitality program and FIGs. 3, 7, and 10 show support for accumulating credits or "receive rewards based on accumulated credit values exceeding predetermined values". Further, on page 4, lines 13-23 of the Specification as originally filed shows that the employer can determine the level of membership made available to the employees and that this membership can be **compulsory** or voluntary. Each member is setup to "receive rewards based on accumulated credit values exceeding predetermined values". Page 2, lines 9-11 (and the remainder of the Specification in general) state

that rewards are allocated "to members who accumulate credit values exceeding predetermined values".

Accordingly, support for claimed subject matter of "wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values" is shown in at least FIGs. 1, 3, 7, and 10; page 4, lines 13-23; and page 2, lines 9-11 of the Specification as originally filed.

It should be noted that even though some of the language was not *ipsis verbis* (not in the identical words) in specification the Examiner is respectively reminded that this language was sufficiently described in at least FIG. 1; page 2, lines 9-11; and page 4, lines 13-23 of the Specification as originally filed, albeit not in the identical words.1 Very recently the Federal Circuit in Allvoice Computing PLC v. Nuance Communications, Inc. (October 12, 2007) addressed the question of definiteness under 35 U.S.C. §112, 1st Par. and stated "*This court concludes that the reference to DDE in the specification is a structure corresponding to the "output means" clause of claim 60. With that understanding of the proper parameters of the claim, the record shows that an artisan of ordinary skill would understand the bounds of the claim when read in light of the specification. KSR Int'l Co. v. Teleflex Inc., 550 U.S. ----, 127 S.Ct. 1727, 1742 (2007) ("A person of ordinary skill is also a person of ordinary creativity, not an automaton."). Thus, the record shows that claim 60 satisfies the definiteness requirement.*"

Also, the exact terms need not be used *in haec verba* to satisfy the written description

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1 If, on the other hand, the specification contains a description of the claimed invention, albeit not in ipsis verbis (in the identical words), then the examiner or Board, in order to meet the burden of proof, must provide reasons why one of ordinary skill in the art would not consider the description sufficient. See In re Alton (Fed. Cir 1996) (Emphasis Added). See also Fujikawa v. Wattanasin (Fed. Cir. 1996), ipsis verbis, As the Board recognized, however, ipsis verbis disclosure is not necessary to satisfy the written description requirement of section 112. Instead, the disclosure need only reasonably convey to persons skilled in the art that the inventor had possession of the subject matter in question. In re Edwards, 568 F.2d 1349, 135152, 196 USPQ 465, 467 (CCPA 1978). See MPEP 2163 subsection II 3 (a), second to last paragraph.

requirement of the first paragraph of 1.25 U.S.C. 112 *Eiselstein v. Frank*, 52 F.3d 1035, 1038, 34 USPQ2d 1467, 1470 (Fed. Cir. 1995); *In re Wertheim*, 541 F.2d 257, 265, 191 USPQ 90, 98 (CCPA 1976). See also 37 CFR 1.121(e), which merely requires *substantial* correspondence between the language of the claims and the language of the specification.

With respect to the Examiner's statement of:

> Even if we assume that "a default setting" is filling out a form, and checking a box for accepting membership of Vitality; then figures 1, 3, 7, 10 all describe different situations, such as figure 1: "New employer joins vitality", figure 3: "Claim vitality points for existing HRC/RWFL membership", figure 7: "Member/dependant visits run/walk for life", and figure 10: "Score various vitality points" and not all of the figures recite a form that the employer completes.
>
> It is already very confusing that the terms of "insurance provider", "Momentum Health" or "MH", "MH U/W Ops" where "U/W' is an abbreviation for "underwrite", "Discovery", and Scheme" have been used interchangeably in the Specification as originally filed to mean "insurance provider" (as explained by the Appellant in Remarks of 2/17/2009 communication); Appellant now points out all these figures of different situations as "a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values".

Appellants suggest that these remarks are misplaced. For example, the "default setting" of the claimed invention is not merely filling out a form and checking a box, as asserted by the Examiner, but is a default setting associated "with the medical insurance plan…for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values". As discussed above, FIG. 1 (and at least page 4, lines 13-23 of the Specification as originally filed) provides support for the default setting to be opted-in and FIGs. 3, 7, and 10 (and at least page 2, lines 9-11 of the Specification as originally filed) provides support for receiving rewards based on accumulated credit values exceeding predetermined values. Accordingly, this argument made by the Examiner that FIGs. 3, 7, and 10 are different than FIG. 1 is misplaced.

Accordingly, the Specification as originally filed provides support for the claimed subject matter of "wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values" and the objection to the Specification under 35 U.S.C. §132(a) should be withdrawn.

Rebuttal to Examiner's Answer Directed to the *Douglas* Reference

The *Douglas* reference teaches that a physician creates a program for an individual to follow (See the *Douglas* reference at FIG. 1, 2, 5, and 39 and col. 6, lines 7-25), whereas an insurance provider in the presently claimed invention has control over health related facilities and/or services and the rewards that are offered to individuals for participating in the health related facilities and/or services. Allowing an insurance provider to have control over these aspects as compared to a physical creating a program for an individual is advantageous because the insurance provider can tailor its offerings to suit its business goals and members. For example, the insurance provider knows what its members are submitting claims for and, by defining the facilities and services, the insurance provider is able to monitor the effect that their facility/service defining strategy is having on member claims. Therefore, the insurance provider is able to tailor the facility/services offered to its members to achieve maximum member claim reduction. Also allowing the insurance provider to tailor rewards offered to its members, the insurance provider is able to allocate specific rewards that will attract members likely to have lower number of claims.

Also, *Douglas*, in contrast to the presently claimed invention, does not provide the member with access to the third party facilities and services and does not monitor the usage of these, but rather receives data input by the member. *Douglas* may provide reward but certainly does not do this in the context of a health insurance plan. The independent claims clearly recite that the computer system of the insurance provider is performing the method and this language seems to be ignored by the Examiner. Douglas merely instructs a person to perform certain actions, but does not provide them with access to do these actions. The presently claimed invention, on the other hand, offers, by the computer system managed by the insurance provider, the at least one of a plurality of

health-related facilities and a plurality of health-related services to members of the medical insurance plan. One of advantage of this aspect of the presently claimed invention is that the members are provided free or subsidized access to facilities/services. This motivates the member to utilize these facilities/services, whereas if the members were not offered these facilities/services they would most likely not utilize them. The benefit to the insurance provider is that by offering these facilities/services to its members claims made by the members are reduced. This allows that insurer to keep insurance premiums down as claims on the insurance plan are less.

With respect to the Appellants' remarks/arguments in the Appellants' Appeal Brief directed towards the claim elements of:

> defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan;
>
> offering, by the computer system managed by the insurance provider, the at least one of a plurality of health-related facilities and a plurality of health-related services to members of the medical insurance plan

the Examiner provides the following response on page 15 of the Examiner's Answer:

> Examiner respectfully submits that "business of a medical scheme" or "health insurance plan" is described in the present specification on page 2 as: "The South African "Medical Schemes Act, No. 131 of 1998, Chapter 1, Section 1 - Definitions, contains the following definition of the term "business of a medical scheme:
> "the business of undertaking liability in return for a premium or contribution
> a) to make provision for the obtaining of any relevant health service;
> b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and
> c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme;"
> ...A medical scheme according to this definition will be understood by those skilled in the art as being equivalent to a traditional indemnity health insurance plan.
> The plurality of health-related facilities and/or services may include membership of health clubs, gymnasiums or fitness programs, weight loss programs or programs to quit smoking, for example."

> Therefore according to present specification, an insurance provider "grant assistance for a relevant health service" and "render a relevant health service, either by the medical scheme (insurance provider) or by any supplier in association with in terms of an agreement with a medical scheme". Applicant (appellant) admits that "insurance provider renders a relevant health service to the members.

Appellants respectfully point out that the Examiner is misquoting the Specification as originally filed and therefore, the above remarks provided by the examiner are misleading. For example, the above section of the Appellants' Specification is provided in the "Summary of the Invention". In the "Summary of the Invention" the Appellants first provided a summary of the method of "managing the use of a medical scheme by members thereof". This summary of the method provided by the present invention included the phrase "health-related facilities and/or services". Appellants then provided a definition of "business of a medical scheme" as found in the South African "Medical Schemes Act, No. 131 of 1998". After this definition was provided, the Appellants further provided additional summaries of the invention such as by providing examples of the health-related facilities/services. As seen above, the Examiner seems to be trying to group the Appellants' summary of the invention into the definition of "business of a medical scheme" as found in the South African "Medical Schemes Act, No. 131 of 1998", which is misquoting the Specification and, therefore, misleading. The Appellants summary of "The plurality of health-related facilities and/or services may include membership of health clubs, gymnasiums or fitness programs, weight loss programs or programs to quit smoking, for example" is **not** part of the "business of a medical scheme" definition provided by South African "Medical Schemes Act, No. 131 of 1998" and is not suggested by this definition either.

Appellants do not admit that "insurance provider renders a relevant health service to the members", as asserted by the Examiner, since the Examiner seems to be implying that "relevant health service" comprises the "plurality of health-related facilities and/or services" as recited by the present invention. The Appellants in the "Summary of the Invention" of the Specification as originally file state that this definition given by South African "Medical Schemes Act, No. 131 of 1998" is "equivalent to a traditional indemnity health insurance plan". The independent claims

clearly distinguish between "relevant health service" as defined by the South African "Medical Schemes Act, No. 131 of 1998" and health-related facilities/services. For example, the independent claims recite "providing at least one of relevant health services and assistance in defraying expenses incurred in connection with rendering such relevant health services". These claim elements are defining a first aspect of the medical insurance plan of the present invention. The independent claims then go on to recite "defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan". As can be seen, the independent claims clearly distinguish between "relevant health services" and "a plurality of health-related facilities and a plurality of health-related services". Therefore, an insurance provider that merely offers relevant health services does not teach or suggest "defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan".

The Examiner further states on page 16 of the Examiner's Answer that:

> Douglas teaches "Referring to FIG. 1, in a presently preferred embodiment of the invention, the patient 10, physician 12, case advisor 14, and health plan payor 16 (such as an HMO, insurance company or self-insured employer), all provide input to and/or receive output from the therapeutic behavior modification program's compliance monitoring and feedback system." (Douglas; col. 5, lines 28-34), therefore, payor inputs and receives output from the system.

As can be, the Examiner states that the *Douglas* reference teaches "defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan" merely because the *Douglas* reference states that an insurance company "provide[s] input to and/or receive[s] output from the therapeutic behavior modification program's compliance monitoring and feedback system".

However, all throughout the disclosure the *Douglas* reference only teaches that a physician "can then recommend a health care maintenance or recovery program which requires the patient to:

take certain medications; participate in a support group; and control risk factors by altering his or her diet, following an exercise program, and managing stress levels." The *Douglas* reference also states that a physician can write a prescription for the program and then "send the information to a case advisor, who then sets the patient up on the system". The *Douglas* reference defines a case advisor as "doctor, nurse, and/or other trained medical professional experienced in case management protocols and practices". See the *Douglas* reference at col. 6, lines 7-27. Nowhere does the *Douglas* reference teach or suggest that the insurance provider defines "at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan". Merely stating that an insurance provider can provide input to and/or receive output from the system of *Douglas* does not render the presently claimed invention obvious especially when the *Douglas* reference explicitly teaches that it is the doctor or case advisor that places the patient into a program.

Also, the *Douglas* reference only states that an insurance provider can access the results of a user's participation in the health maintenance program of *Douglas*. See the *Douglas* reference at col. 19, lines 27-48. This further shows that only the doctor or case advisor of *Douglas* places a patient into the health maintenance program. The Appellant respectfully suggests that the Examiner is improperly broadening the scope of the *Douglas* reference. For example, the *Douglas* reference only teaches that a health payor is only able to access the system to view compliance information and comparative cost information. See the *Douglas* reference at col. 19, lines 26-67 to col. 20, lines 1-18. These sections of the *Douglas* reference clearly show that the health payor does not define and offer health related facilities/services to a member, but merely reviews compliance and comparative cost information.

Even further, claim 1 recites "**defining**, by the computer system managed by the insurance provider, **at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan**". As can be seen, the insurance provider defines health-related facilities and/or health-related services that are to be associated with the medical insurance plan. A doctor or case advisor in *Douglas* determining goals, such as quitting

smoking, is not the same as an insurance provider defining health-related facilities and/or health-related services that are to be associated with the medical insurance plan. A doctor in *Douglas* is merely setting goals and is not defining facilities and/or services to be associated with a medical insurance plan.

The Examiner goes on to state on pages 16-17 of the Examiner's Answer that:

> Also, Douglas teaches "In an exemplary scenario, a physician diagnoses an individual with an ailment. The physician may then recommend a health care maintenance or recovery program which requires the patient to: take certain medications; participate in a support group; and control risk factors by altering his or her diet, following an exercise program, and managing stress levels." (Douglas; col. 6, lines 7-13).
>
> Examiner considers that it makes more sense for a physician to recommend any health-relevant service such as exercising, since the physician knows about the patient's detailed health conditions, and can recommend the optimum program for the patient rather than an insurance company asking a patient to do a certain exercise. The system of Douglas offers the patient health-related services, wherein the health plan payor is a component of the system.
>
> And since applicant's specification describes that the insurance plan renders relevant health services to the members, insurance provider in Douglas would be able to input/output information about relevant health services for the members.

The Examiner seems to be inferring that even though the claims state "defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan" that it "makes more sense for a physician to recommend any health-relevant service such as exercising, since the physician knows about the patient's detailed health conditions, and can recommend the optimum program for the patient rather than an insurance company asking a patient to do a certain exercise". In other words, the Examiner seems to be acknowledging that the *Douglas* reference does not teach the presently claimed invention, but that this does not matter since it "makes more sense for a physician to recommend any health-relevant service such as exercising…"

Accordingly, the presently claimed invention should be allowed for this reason.

Furthermore, with respect to the Examiner's statement of "And since applicant's specification describes that the insurance plan renders relevant health services to the members, insurance provider in Douglas would be able to input/output information about relevant health services for the members", the Appellants have already shown above that "relevant health services" is a completely separate and distinct claim element than "...a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan...". The Examiner is improperly combining these two claim elements and has failed to show how Douglas teaches or suggests "...a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan..."

With respect to the presently claimed "offering, by the computer system managed by the insurance provider, the at least one of a plurality of health-related facilities and a plurality of health-related services to members of the medical insurance plan", the Examiner cites the same sections of the *Douglas* reference discussed above. The remarks and arguments given above are also applicable to this claim element and for sake of compact prosecution will not be repeated. For example, nowhere does the *Douglas* reference teach or suggest that the insurance provider offer these facilities or facilities. The Examiner's comments in the Response to Arguments section of the Final Office Action of "The system of Douglas offers the patient health-related services, wherein the health plan payor is a component of the system" is improperly broadening the scope of the *Douglas* reference. Just because the system of *Douglas* provides the on-line community for the user to participate in does not teach or suggest that the health plan payor offers these services. It is irrelevant that the health plan payor is part of the system because the presently claimed invention recites that the insurance provider itself provides the facilities and/or services. Accordingly, the presently claimed invention distinguishes over the *Douglas* reference for at least these reasons as well.

The Examiner further states on page 17 of the Examiner's Answer that:

> Appellant argues: Douglas does not teach "the rewards are allocated to

> members who accumulate credit values exceeding predetermined values"(pages 14-15 of the arguments); Examiner respectfully recites that Douglas teaches "...Users may earn points by good participation in the program and by reaching certain milestones. For instance, points may be earned for good attendance at meetings, good participation during the meetings, chairing a meeting, or losing a certain amount of weight, if this was a goal to be accomplished." In col. 14, lines 37-47.

Users may earn points in Douglas by good participation, but the presently claimed invention recites:

> allocating, by the computer system managed by the insurance provider in response to the monitoring, a credit value to each member according to their use of the at least one of a plurality of health-related facilities and a plurality of health-related services; and
>
> allocating, by the computer system managed by the insurance provider, rewards to members who accumulate credit values exceeding predetermined values

The Examiner seems to be ignoring the fact that the presently claimed invention recites that the computer system managed by the insurance provider is allocating the points and rewards and that rewards are allocated based on accumulating credit values exceeding predetermined values.

Col. 19, lines 26-67 to col. 20, lines 1-18 of Douglas explicitly shows how the health payor interacts with the system, and does not teach or suggest that the health payor in Douglas allocates credit vales to members based on health related facility/service usage or allocating a reward(s) to the member based on the credit values. Col. 14, lines 37-42 of the *Douglas* reference merely state that a user can earn points, but these points are awarded **by the behavior modification program and not by the insurance provider**. The behavior modification program is **not** managed, provided, or part of the health payor in Douglas.

Also, nowhere does the *Douglas* reference teach that the rewards are allocated to members who accumulate credit values exceeding predetermined values. The *Douglas* reference does not require the rewards to be allocated **only when the accumulated credit value exceed a predetermined value(s)**. In other words, the *Douglas* reference merely gives rewards for finishing

a program, etc. For example, the *Douglas* reference at col. 19, lines 38-52 states:

> Users may earn points by good participation in the program and by reaching certain milestones. For instance, points may be earned for good attendance at meetings, good participation during the meetings, chairing a meeting, or losing a certain amount of weight, if this was a goal to be accomplished.
>
> Rewards range from the symbolic kind, such as getting "gold stars" that commend a user for his or her progress, to reward points and frequent flier miles which may be exchanged for goods in the village store 78 or plane tickets in the village travel agency 82, respectively.

As can be seen, nowhere does the *Douglas* reference teach or suggest "that the rewards are allocated to members who accumulate credit values exceeding predetermined values". The above teaching of the *Douglas* reference does not teach or suggest "credit values exceeding predetermined values".

Accordingly, the presently claimed invention distinguishes over the *Douglas* reference for at least these reasons.

Rebuttal to Examiner's Answer Directed to the *Luchs* Reference

With respect to the Luchs reference, the Examiner states on pages 17-18 of the Examiner's Answer that:

> Appellant argues: Luchs does not teach "wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding a predetermined values" (in page 16 of the arguments); Examiner respectfully submits that Luchs teaches "a computerized insurance premium quote request and policy issuance system" (title), where "To assist the operator in entering the appropriate data, a series of data comprising a "form" is displayed on his terminal by the central processor, and he merely enters the pertinent information in the blanks provided. This information constitutes such things as the insured's name and address, the risk to be insured, the limit of the insurance, and any other information necessary in providing a policy application or premium quotation. Although all of the data requested by the form must be completed in order to proceed with writing the insurance policy, for the purpose of quoting the premium which would be due, only certain minimal information need be entered. This information is correlated in the central processor, resulting in premium quotation data which is then transmitted back and displayed at the operator's terminal." In col. 3, lines 17-38. As analyzed above in the section of B, the definition of insurance plan includes providing any relevant services to the members and as analyzed in section A, a default setting associated with the medical insurance plan is filling out a form, and checking the necessary parts of the form. Therefore Luchs teaches a default setting associated with the medical insurance plan.

Appellants respectfully disagree and suggest that the Examiner is mischaracterizing and improperly broadening the scope of *Luchs*. The *Luchs* reference, at best, merely teaches insurance information on a form. See the *Luchs* reference in general. *Luchs* is directed at conventional insurance programs available in 1986 and never teaches or suggests a medical insurance plan where members can receive rewards based on accumulated credit values exceeding predetermined values. Therefore, *Luchs'* teaching of "any other information necessary in providing a policy application or premium quotation" when taken in view of the other teachings of *Luchs* fails to teach or suggest "loading member application forms in a computer system managed by an insurance provider, wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding a predetermined values".

Furthermore, with respect to the Examiner's statement of "As analyzed above in the section of B, the definition of insurance plan includes providing any relevant services to the members and as analyzed in section A, a default setting associated with the medical insurance plan is filling out a form, and checking the necessary parts of the form. Therefore *Luchs* teaches a default setting associated with the medical insurance plan", the Appellants point out, as already discussed above, that a default setting of the presently claimed invention is not merely filling out a form, but is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values. Neither the *Douglas* and/or the *Luchs* references teach or suggest this claim element.

Rebuttal to Examiner's Answer Directed to the 1.132 Affidavit

With respect to the Appellants' 1.132 Declaration, the Examiner states on page 18 of the Examiner's Answer that:

> The declaration includes a research paper (UBS Investment Research) authored by Michael Christelis and the first page of the research indicates "UBS does and seeks to do business with companies covered in its research reports. As a result, investors should be aware that the firm may have a conflict of interest that could affect the objectivity of this report. Investors should consider this report as only a single factor in making their investment decision." Therefore there is a conflict of interest between the author (and UBS) and the inventors (Discovery Holdings Ltd.).
>
> The declaration states "...We believe that Vitality provides superior life insurance margins and medical scheme membership growth potential (despite its already large size) through selection effects, significantly lower mortality claims, health claims and lapse experience, and a brand of its own that has become a household name in the affluent market in South Africa...".
>
> Therefore the report provides other reasons for success of the Vitality and the success is not related with the claims.

Appellants respectfully disagree with the Examiner because, as shown below, the 1.132 Declaration including the report is directed to the claimed subject matter. Specifically, Michael Christelis is an analyst for UBS South Africa, which is independent from the assignee of the present invention (Discovery Life Limited). Michael Christelis is the author of the UBS Investment Research. A copy of the UBS Investment Research is attached. On page 12 of the UBS Investment Research, Michael Christelis describes "*Key Advantage: Vitality. Can it be copied?"* In this section, Michael Christelis enumerates three reasons for the commercial success of the claim invention (The Vitality System) with bullet points entitled "*Innovations, 'Opt-out' rather than 'opt in' and Integration.*" This corresponds to the language recited in independent claim 1 and dependent claim 19 of wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values.

This is the "opt in" innovation cited in the UBS Investment Research report. Also independent claim 1 and 18 recites a computer system managed by an insurance provider. The insurance provider provides this integration. These are the reasons for the market success of the claimed invention (The Vitality System) as reported by UBS South Africa. This market success shows the nexus to the claim language of "wherein the insurance provider undertakes liability in the medical insurance plan in response to receiving one of the premium payment and the contribution payment." The Examiner cites investment boilerplate language to point out that "UBS does and seeks to do business with companies covered by research reports". However, there is no evidence that UBS does business with Discovery Life Limited, nor has UBS done business with Discovery Life Limited. Further the Examiner points to other language to support the argument that the report provides other reasons for success of Vitality. However, as stated in the report, the "key advantage" has been unambiguously highlighted.

Conclusion

Accordingly, in view of the remarks and arguments, the *Douglas*, *Luchs*, and any other reference cited by the Examiner fails to teach or suggest all of the claimed features of the present invention. Furthermore, the 1.132 Declaration is proper and applicable to the presently claimed invention. Therefore, Appellants respectfully request that the Examiner's rejections be reversed.

Respectfully submitted,

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